Department of Health and Human Services

Health Care Financing Administration
Region III

HCFA
MEDICARE • MEDICAID
Health Care Financing Administration

Suite 216, The Public Ledger Bldg
150 S. Independence Mall West
Philadelphia, PA 19106-3413

Gregg C. Sylvester, M.D.
Secretary
Delaware Health and Social Services
Main Building
P.O. Box 906
New Castle, DE 19720

Dear Dr. Sylvester:

Re: Delaware's Request for a Home and Community-Bases Services Waiver to Serve Individuals with Acquired Brain Injury (HCFA Control # 0363)

The State of Delaware has requested a home and community-based services waiver to provide case management, personal care, respite care, adult day health, habilitation (residential), environmental accessibility adaptations, specialized medical equipment and supplies, personal emergency response systems, companion, family training, attendant care, adult residential care (assisted living), cognitive behavior and substance abuse services to individuals with acquired brain injury who are from 18 to 64 years of age and who meet a nursing facility level of care.

Based on our review of the waiver application, we have determined that it does not fully conform to the statutory and regulatory requirements. Please provide the following additional information and/or clarifications.

Executive Summary

- On page 2 of the application, Delaware indicates in item 4b that individuals who are "at risk for placement in a nursing facility" are eligible for the waiver. Please clarify this language to reflect that these individuals will meet the nursing facility (NF) level of care and not be "at risk of NF level of care."

- The signature on page 11 is not legible. Please submit a revised signature page.

Appendix B

- Please check only one service definition for case management. If you choose to use the other service definition as provided, then the "x" should be removed from the streamlined format definition.

- On page 15, the State indicates that it is “the contracted case management agency’s responsibility to work with DSAAPD to ensure the full range of appropriate services are provided to the consumer . . .” This statement could be read to mean that the case management agencies will be selected by the State or some other entity rather than by the consumer from among all agencies that are qualified to perform the service and willing to do so. According to Section 1902(a)(23) of the Social Security Act, Medicaid consumers may obtain covered services from any institution, agency or person qualified to perform the service who undertakes to provide him such services. This section cannot be waived under a 1915(c) waiver. Please clarify your intent. If Delaware intends to operate this waiver program only in connection with a 1915(b) waiver, then we must be notified of this relationship. If the 1915(b) and 1915(c) waivers are not approved concurrently to operate in combination, the 1915(c) waiver may not reflect any restriction of providers.

- It appears that case managers must be employed by an agency. Please clarify. If they are to be restricted to an agency, please furnish an explanation of the basis for this requirement. As indicated previously, waiver consumers have the right to select from among those providers who meet the State's reasonable requirements.

- On page 17, the State indicates that a registered nurse or licensed practical or vocational nurse will supervise personal care workers. Who will these nurses work for, and how will they be monitored? Is this specified in the State home health agency regulations?

- On page 17, item 4, you indicate that "personal care services are not provided under the approved State plan." Pursuant to your State plan, Attachment 3.1-A, page 9, 24.,f., personal care services are provided with limitations. Please check the appropriate sub-paragraph and provide any additional information/clarification as necessary.

- How do the adult day health and residential habilitation services differ? The service definitions are very similar and seem to overlap. How is it determined which service a consumer requires?

- On page 30, “family members" are excluded from payment for companion services. How does Delaware define "family members"? While States may expand the definition of "family members," HCFA's restriction of payment is limited to the parents of minor children and spouse to spouse. We note that companions may accompany individuals into the community. If so, will transportation be provided in such cases? Is it an incidental part of the companion service?

- Please explain how the counseling component of family training is different from the behavior and/or cognitive service. The two services seem to overlap.

- The attendant care service, as defined, is very similar to personal care services. What are the differences? What agency is referred to as the “contracting agency” under the supervision requirements?

- On page 33, under assisted living, the language reads that it is a program of personal care and services "which may include." Please change "may include" to "includes," as we cannot approve open-ended definitions.

- On page 34, you have indicated that limited nursing services, such as insulin and other injections and blood sugar monitoring, are included under the assisted living program. Is this allowed under Delaware's Nurse Practice Act?

- The substance abuse service definition is vague in that it could be read to assume that this service is available to individuals who are family members or significant others for treatment of a substance abuse problem rather than to treat the consumer directly. Please clarify. Please identify the State plan service that this service would be in excess of.

Appendix B-2

- The State must provide the licensure, regulation or State administrative code citation wherever it applies.

- We also note that in Appendix B-2, it appears that you restrict the providers of case management, personal care services, adult day care, companion services, and substance abuse services to agencies. Please remove this restriction or provide a satisfactory explanation of why the restriction for each type of service is reasonable given the nature of the service and the target population. Under Medicaid's free choice of provider's policy, a State may only impose standards upon providers that are reasonably related to the provision of the service. In addition, please provide a definition of a "social service agency" if you intend to limit providers of case management to this type of provider and explain why such a restriction is appropriate. Likewise, for personal care, it appears that the providers must be home health agencies, thereby ruling out friends, neighbors, or relatives, or others who may be qualified to perform the service. If you intend to limit providers of personal care to this type of provider, please explain why such a restriction is appropriate.

- Under the respite service, the licensure and certification requirements must be presented for all the providers of respite care listed on pages 18-19.

- In Appendix B-2.A. Licensure and Certification Chart, you indicate that attached standards apply to adult day health and family training. However, we did not find such standards on Attachment 1 to Appendix B-2. It is necessary to provide standards for all waiver services that are sufficient to protect the health and welfare of waiver consumers. Likewise, for residential habilitation, you indicate that the services will be provided by a neighborhood group home or "other appropriate setting." Please define "other appropriate setting" and complete the type of service and the type of provider on the chart and specify the type of license required.

- It is noted that a business license is required for environmental accessibility, specialized medical equipment and supplies, and PERS services unless the provider is a non-profit

agency. Wouldn't some type of license or certification be required if these providers were building and/or installing equipment? Please describe the standards that apply to non-profit agencies?

Attachments to Appendix B-2

- Page 45 indicates that personal care services may be provided by an agency that provides personal care services, such as a home health agency. In the next bullet under licensure, it states that the agency must be licensed as a home health agency. Does this mean that all personal care agency providers must be a licensed home health agency? Again, why are personal care service providers restricted to agencies? The standards under this section seem to be requirements or qualifications rather than standards and should be listed as such. It appears that there are no minimum age or educational requirements for a personal care worker. Is this correct? We concur with the criminal background check but also wonder if these individuals should also receive a physical to determine that they are free from any communicable diseases. Direct care providers should have sufficient training in the use of universal precautions. Also, it would be desirable if the State indicates the amount of hours of training noted in the personal care attachment.

- On page 47, attendant care is listed as attendant services. Throughout the document, this service is listed as attendant care. Please modify to be consistent.

- Would the only service providers qualified to provide substance abuse services be agencies that have programs that are certified to meet Medicaid standards by the Division of Alcohol, Drug Abuse and Mental Health or a certified Drug and Alcohol Abuse Treatment Program or an Alcohol Treatment Program under Delaware Title 16, Chapter 48? If so, this statement would be best described in the first paragraph of the qualifications.

Appendix C

- The State did not use the most recent version of the Appendix C. Please use the most recent version of the Appendix C that was sent out under the cover of State Medicaid Directors letter dated December 23, 1996.

- Regular Post-Eligibility --This section was not completed. Even though you completed the spousal impoverishment post-eligibility section (for individuals with a community spouse) of the waiver application, you must also complete the regular post-eligibility section. The reason for this is that the post-eligibility rules apply to all individuals found eligible under the 42 CFR 435.217 eligibility group, not just to individuals that have a community spouse.

- Spousal Impoverishment Post Eligibility -- You indicated that the personal needs allowance for individuals residing in assisted living facilities or other residential facilities is equal to the Delaware Adult Foster Care Rate. Please advise us of this amount.

Appendix D

- This section indicates that a registered nurse, licensed in the State would perform the evaluations and reevaluations. Will this nurse be an employee of the State or employed by an agency. Is the case manager involved in this process?

- The description of the evaluation/assessment tools indicates that the forms are not attached, but are the same as those used for the current Elderly and Disabled Home and Community-Services waiver. We reviewed the forms attached to this approved waiver and, it is not clear to us which form is actually the form used to document that a NF level of care has been determined. Therefore, we ask that you submit all documents used in the level of care determination process as part of this waiver.

- Section b on page 72 should indicate where the freedom of choice forms are to be maintained. It is not clear what is meant by saying that the Advanced Action and Fair Hearing Notice, Freedom of Choice Awareness Form, Right to Appeal are "in this appendix," and that all other forms are retained in recipient's eligibility records. Please clarify. Are the Advanced Action and Fair Hearing Notice, Freedom of Choice Awareness Form and Right to Appeal Forms maintained at the Medicaid agency or in the waiver client's file?

- The first paragraph on page 73, the Freedom of Choice Awareness Form, states that the individual may be "at-risk" of living in an institution. This language should be clarified to read that the individual meets the level of care of that of an institution and not be "at risk" of that need. Item 3 refers to the qualifying criteria for NF services. Those criteria need to be included in this package. Also, it would be clearer if in the choice section, the individual be advised that they if they do not choose waiver services, they remain eligible for institutional services and that they may change their choice at any time.

- Page 74 also refers to the fact that the recipient may be determined to be likely to require the level of care provided in a nursing facility. This language needs to be clarified to state the recipient must meet a nursing facility level of care.

- The State refers to a Freedom of Choice Form that is used in Delaware's current Elderly and Disabled waiver. Is the form provided as page 73 this document?

- We have comments on language included on page 78 that we believe would be less confusing. We suggest that the second and third sentence of the second paragraph be modified as follows: "If you ask for a fair hearing before the date the change in your benefit takes effect, you will get the same benefits that you have received. These benefits will continue until the hearing officer decides your case." The language in the third paragraph would be less confusing if modified as follows: "You can still ask for a hearing within 90 days of the date this notice was mailed. But your benefits will not stay the same until your hearing." Also, on this form, we believe that the two last bullets and blocks for check off are unnecessary. Continuation of benefits is automatic if the hearing is requested before the adverse action takes effect. (If a person is concerned about possible

repayment, they should wait until after the effective date of action before filing an appeal.)

Appendix E

- Will the case manager alone be responsible for preparing the plan of care or will the case manager work with a team? Will the recipient and/or family be involved?

- The description of the Medicaid Agency's involvement in approval of the plan of care is confusing. The first paragraph indicates that the Department of Health and Social Services is the State Medicaid agency in Delaware. In paragraph 2, you indicate that "the DSAAPD case manager will be responsible for approving the plans of care." Is the DSAAPD case manager an employee of DSAAPD? Also, in paragraph 2, you indicate that "All care plans will be available to the Medicaid office located in the Division of Social Services." This appears to contradict the statement made in the first sentence. Please clarify and explain why you believe your process comports with Federal regulations at 42 CFR 441.301(h)(1)(i).

- Please attach a copy of the plan of care document to be used for this waiver. This needs to be attached so that we can be sure that the waiver reflects DSAAPD's current plan.

Appendix G

- How were the Factor "D" rates developed for the following services: residential habilitation, case management, personal care, companion, and respite services?

- The daily rate for adult day program is much lower than residential habilitation, but is a similar service. Describe the basis for these rates.

- Why will attendant care be reimbursed on an hourly rate while personal care and companion services are to be reimbursed on a daily rate?

- The Year 2 numbers for respite care (in-home and institutional) seem to be reversed for the hourly rates and number of individuals to be served. Please refer to Year 1 for clarification.

- The number of annual units/users for attendant care for Years 2 and 3 appear to be incorrect. It is computed as 700 days—this probably was intended to be 700 hours.

- The cognitive behavior rate per session does not reflect your inflationary increase in Year 2.

- The substance abuse per session rate is $85 per session for both individual and group for Year 1. However, in Year 2, the rate for individual sessions is $93 per session and $14 per session for group. Also, the group rate per session drops from $14 in Year 2 to $13 in Year 3. Please clarify.

- Please delete DME from the Years 2 and 3 Factor "D" charts since DME is not included as a waiver service in Appendix B.

- Why does the rate for environmental modifications double in Year 2 and Year 3?

- You indicate that the figures for "D prime" are the same as "G prime". How were the figures developed?

- Please describe how the average annual lengths of stay (AALOS) were developed for each year.

- We also note that you estimate that waiver recipients will be receiving an average of 11 months of assisted living, case management, and ERS. This is not consistent with your AALOS estimate of 250 days. Please revise your cost and utilization estimates for these services to make them consistent with your AALOS. Please make sure that your cost and utilization estimates for the other services are also consistent with your estimates for AALOS.

Under section 1915(f)(2) of the Social Security Act, a waiver request must be approved, denied or additional information requested within 90 days of receipt, or the request will be deemed granted. The 90-day period in this case ends on January 17, 2001. This constitutes a formal request for additional information. A new 90-day period begins upon receipt of your written response. This request for a waiver carries HCFA control number 0363. Please refer to this number in all future correspondence regarding this request.

Please contact Bill Davis of the Philadelphia Regional Office at (215) 861-4204 if you have any questions.

Sincerely,

Claudette V. Campbell
Associate Regional Administrator
Division of Medicaid & State Operations

cc: Philip Soulé

File: G:\FCHB\HCBSwvrs\DE\01-14-de-tbi-wd-g.doc

FILE COPY

OFFICE	SURNAME	DATE	OFFICE	SURNAME	DATE
FCHB, DMSO	W. Davis	17/01/2001			